MDR Tracking Number: M5-04-2612-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4/19/04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Functional Capacity Evaluation (FCE) rendered on 12/08/03 was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6/25/04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 97545-WC-CA and 97546-WC-CA for dates of service 11/20/03 through 11/21/03 were denied by the carrier as "A" Pre-authorization not obtained. Per Advisory 2001-14 preauthorization for Work Conditioning programs are not required for CARF accredited providers. Reimbursement is recommended in the amount of $288.00 ($72.00 x 4).

CPT code 97545-WC-CA and 97546-WC-CA for dates of service 12/01/03 through 12/05/03 had EOBs; however, no reasons for denial were listed. There were no other EOBs submitted by neither the Requestor nor the Carrier. These dates of service will be reviewed in accordance with Rule 134.202 effective 8/01/03. Since the Carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $576.00 ($72.00 x 8).

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with TWCC reimbursement methodologies for Return to Work Rehabilitation Programs for dates of service after August 1, 2003 per Commission Rule 134.202(e)(5).

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2).

This Decision and Order is hereby issued this 27th day of October 2004.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PRD/prd

June 23, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected items and dates in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-2612-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing

healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: office notes, physical therapy notes, FCE and designated doctor reports.
Information provided by Respondent: office notes, physical therapy notes, FCE, disability exam and impairment exam.
Information provided by Treating Doctor: office notes and hand surgeon consultation.

Clinical History:
The patient is a 49-year-old female who, on ___, injured her right hand while working. She felt an immediate sharp pain in her thumb. She was treated conservatively at first, but on 06/24/03, underwent operative procedure in the form of right trigger thumb release, followed by extensive post-operative physical therapy and eventually, work hardening/conditioning.

Disputed Services:
FCE on 12/08/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the items in dispute as stated above were not medically necessary in this case.

Rationale:
According to the medical records – specifically, the TWCC-73 dated 08/08/03 – the surgeon determined that the patient was able to return to light duty on 08/06/03. With this professional opinion given by the physician who actually performed the operative procedure, the medical necessity for the FCE cannot be supported after 08/06/03.

Sincerely,